APPENDIX 2

AUDIT TRACKER UPDATE
LIMITED ASSURANCE REPORTS
OUTSTANDING RECOMMENDATIONS

Executive Lead - Chief Operating Officer							
ABMU 1617-009 **Backlog Maintenance** **Report Issued 09/10/2017**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	1	There is no specific policy at the UHB relating to the management of backlog maintenance. The UHB is placing reliance on the WG PBC that has been approved yet there is no evidence to suggest that a strategic view is being taken of the longer-term requirements / projects that will need to be addressed vs. those which are bid upon. The overarching Service Strategy referred to in the PBC will 'expire' 31 March 2018. Management has stated that association with the ARCH collaboration is seen as a mechanism to address the longer strategy for Estates. However, there is no narrative information to support the detail of the longer term strategy / direction of the UHB; and is subject to the success of the collaboration which has yet to be tangibly demonstrated. Management will draft and issue an Estates Strategy which specifically identifies the longer term direction of the UHB, how it aligns with ARCH and the UHB's Service Strategy; and how backlog maintenance is to be managed i.e. targets for reducing significant backlog and how it is to be achieved in terms of capital delivery plans	**High**	The directorate, as part of the Arch project, is developing an overarching strategic plan for its estate. This will be based upon the six facet survey that the Health Board is seeking to commission this financial year. The Health Board is developing specification for the completion of a six facet survey which will allow the Health Board to take an informed review of the estate under its control. The Health Board had approached Welsh Government for central funding for the provision of a six facet survey as this had been centrally funded for another Health Board. However the Health Board has not had confirmation of this funding and therefore is seeking to start the process utilising existing discretionary capital.	31/12/2018	**Undated** A draft estates strategy was prepared April 2020 however this has not been taken forward due to the pandemic **Undated Comment by A&A** Outstanding.	None Entered
	4	With regard to the maintaining of the detail on OAKLEAF, it has been observed that the updates are not appropriately delegated. The Assistant Director of Strategy (Estates) currently updates and maintains the system on an annual basis, rather than the system being updated from an operational basis with greater frequency. OAKLEAF categorises all assets by condition and risk, an exercise which will be performed on an annual basis. However, it was not evident that this information was extracted from the system to assist in the categorisation of work when bidding for capital funding; rather reliance placed on accumulated knowledge used to populate the departmental risk register The ownership of managing the OAKLEAF system will be reviewed to ensure timely, operational information is reflected	**Medium**	The Assistant Director of Strategy (Estates) formally coordinated the OAKLEAF return completion. In June 2017 he updated the database and advised each of the Estates Managers that they were now responsible for maintaining the information within the OAKLEAF system. Capital bids can only be made if the item is listed within the backlog maintenance system (excluding statutory work). Each estates department has a performance review every 6 to 8 weeks. It is now intended that this review will include backlog as an agenda item.	01/12/2018	**Undated** A draft estates strategy was prepared April 2020 however this has not been taken forward due to the pandemic **Undated Comment by A&A** Outstanding. Evidence awaited to confirm closure (also noting management comments).	None Entered

SBU 1920-07 Capital Systems Financial Safeguarding Report Issued 13/11/2019	Rec Ref	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	3	Estates procurement activity was reviewed for the period April 2018 to July 2019, including an examination of all relevant Estates cost centres to determine patterns of unusual activity. This identified a significant number of individual orders below £5,000 in value placed with certain contractors. These were reviewed in more detail and discussed with Estates managers, and it was confirmed that: – The above relate primarily to maintenance/repairs – No formal competitive exercises had been undertaken to confirm that these contractors provided best value; – No competency vetting (including, e.g. appropriate industry accreditation checks, health and safety policies etc.) could be demonstrated – Mgmt. advised that the refrigeration contractor's qualifications should be held within an online portal, however evidence was not provided. – Declarations of interest proformas had not been completed (see also the Capital Systems report 2018/19). The Estates department utilises maintenance contracts to manage longer-term requirements for the provision of maintenance and inspection/testing services for estates infrastructure/ equipment, and in some instances the associated breakdown and repair works. Effective from January 2018 the local NWSSP Procurement Services Maintenance team manages a number of these maintenance contracts. However, it was evident from the above, that not all maintenance areas are covered by appropriate contract arrangements. Note: see also Water Management, COSHH, Backlog Maintenance, Capital systems (2018/19) reports previously issued re: maintenance contracts etc. Appropriate procurement controls should be implemented for contractors employed below current quotation thresholds	**High**	Agreed. Appropriate procurement controls will be developed for utilisation within the estates department. These will specifically consider repeat/multiple orders with key contractors/suppliers.	31/12/2019	**Undated** Working with procurement colleagues we have targeted the biggest area of spend identified within the audit. The Health Board has completed a register of all the refrigeration equipment and work has commenced on developing the specification for the refrigeration contract. The department are working with procurement colleges with a view to going to the market. This has been put on hold due to pandemic	None Entered
	4a	An assessment of all current (and required) maintenance contract arrangements should be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee as appropriate; and associated maintenance contracts implemented	**Medium**	Accepted. A review of all maintenance contract requirements across the estate will be undertaken and reported to the Capital Monitoring Group/Health and Safety Committee for consideration and action as appropriate.	01/01/2020	**Undated** Details of all existing maintenance contracts have been developed and will be shared at the next Operational Health & Safety Group. The Department has had a meeting with procurement to improve existing arrangement and have identified the potential benefits of a procurement officer role within the department on a spend to save basis to extend and develop contract management	None Entered

SBU 1920-007 Capital Systems Financial Safeguarding Report Issued 13/11/2019 Cont.	Rec Ref	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	11	The Estates Board and Capital Programme Group receive Estates procurement expenditure reports (including the discretionary capital allocation) for monitoring against agreed allocations. Both forums met on a monthly basis, with relevant issues discussed in accordance with their formal terms of reference. The following issues were noted: The Estates Board terms of reference (dated 2014) requires updating i.e. most notably to reflect the recent changes following the reorganisation in April 2019; and The Assistant Director of Estates was not in regular attendance at the Capital Programme Group (with 7 of the last 12 months' meetings not attended). No other Estates representatives attended in his absence. Estates representation at the Capital Programme Group should be improved	**Low**	Agreed. Where the Assistant Director of Estates is unable to attend, alternative Estates representation will now be sent where appropriate. Additional monitoring groups have also recently been set up, including a monthly Infrastructure meeting and two-monthly Contracts group.	01/01/2020	**16/12/2019** Minutes of the following meetings are available – Project Management – Capital Monitoring – Capital Infrastructure – Clinical Services Plan – Capital Groups	None Entered

Executive Lead – Director of Corporate Governance							
ABMU 1819-006 **Board Assurance Framework** **Report Issued 08/03/2019**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	6	The Primary Care and Community Services development of a Unit Level Assurance Framework will include the submission of a formal review of the framework to the Unit Management Board in June 2019. The Director of Corporate Governance should undertake an evaluation of the effectiveness of the Unit Assurance Framework and consider implementation of the Framework across all other Service Units.	**Medium**	The Risk Management Group will review the progress and consider recommending a standard approach to other Units	01/12/2019	**Undated** The ability of the Primary, Community and Therapies Service Group (previously Primary Care and Community Services) to develop a Unit Level Assurance Framework has been significantly hampered by the resource demands placed on it as a result of the Health Board's response to the COVID-19 pandemic. The Service Group's Nurse Director and Quality & Safety Manager have re-affirmed their commitment to this process, however given current resource pressures, it has not been possible to put definitive timescales or deadlines in place at this time. This matter will be revisited and updated during Q1 of 2021/22.	31/07/2021

Executive Lead – Director of Finance							
ABMU 1920-016 **Procurement No PO – No Pay** **Report Issued 19/12/2019**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	1	The Service Level Agreement between SBU and NWSSP for the provision of procurement services was inconsistent with those relating to other NWSSP function, and not as clear on the respective roles & responsibilities of each. We would recommend that the Health Board liaise with colleagues in the NWSSP to enhance the clarity of its SLA to ensure roles & responsibilities are clear.	**Medium**	It is noted that the SLA for the provision of Procurement Services by NWSSP to SBU requires more clarity with regard to respective roles and responsibilities of each organisation. The relationship between both parties has developed significantly since the introduction of a shared service model but this has not been reflected formally through the SLA. The SBU Head of Accounting and the NWSSP SBU Head of Procurement will meet in January 2020 to discuss and agree the respective roles and responsibilities for each organisation. This will be reviewed and approved by the SBU Director of Finance and the NWSSP Director of Procurement Services with an updated agreement in situ by the end of March 2020	31/03/2020	**Undated** NWSSP Head of Procurement and SBUHB Head of Accounting & Governance met in March 2021 to discuss proposed changes to the SLA. The revised draft document is currently being produced.	30/06/2021
	3	NWSSP Procurement Services were engaged in assisting to resolve the number of invoices on hold arising from introduction of the No PO No Pay policy. However, there were no structural oversight arrangements in place to monitor their progress and ensure action taken within the Health Board where required. We would recommend that more formal arrangements be established to ensure more rigour is applied to driving improved compliance.	**Medium**	It is intended to include compliance with the No Po No pay policy in reporting packs being produced for SDU's. An escalation process will be developed for noncompliance which will dovetail in with the work being done on an all Wales basis through the All Wales P2P Group to develop an all Wales escalation process	31/03/2020	**Undated** Contents of Reporting Pack being worked through by the Finance Reporting and Insight Group. Now likely to be summer 2021. Delayed due to impact of COVID.	31/08/2021
	4(i)	Our review of selected areas and discussion with management indicated a lack of formal clarity regarding management ownership of contracts. Management should consider these issues when reviewing SLA and FCPs. The Director of Finance with the support of the NWSSP Head of Procurement is establishing an improved framework for the management of contracts. We would highlight these issues for attention as part of that process.	**High**	As referenced the development of a Contract and Commercial Relationships register will allow the organisation to clearly assign SRO and day to day management responsibility to nominated individuals. The register will be issued in January 2020 for initial completion by directorates and a full launch will take place in April 2020.	30/04/2020	**Undated** Contract programme developed. This has been shared with Finance Business Partners for comment and updating. To be reissued. Procurement to Pay e-manual pages 44-50 (implementation and contract management) provides further guidance on this	None Stated

ABMU 1920-016 Procurement No PO – No Pay Report Issued 19/12/2019 Cont.	Rec Ref	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	4(ii)	Our review of selected areas and discussion with management indicated a need for operating procedures for complex services. Management should consider these issues when reviewing SLA and FCPs. The Director of Finance with the support of the NWSSP Head of Procurement is establishing an improved framework for the management of contracts. We would highlight these issues for attention as part of that process.	**High**	Procurement and Finance will support SRO's in developing guidance for accessing complex requirements going forward. This will however need to be owned by SRO's as the main purpose of the document will be operational in nature. The contracts register template will be amended to allow for signposting to guidance documentation that is developed.	31/07/2020	**Undated** This will be facilitated by the proposed Procurement business partner approach going forward (pending funding of Procurement posts). Procurement to Pay e-manual includes guidance for SRO's	None Stated
	4(v)	Our review of selected areas and discussion with management indicated difficulties in correlating invoice records relating to bed usage with records received from the supplier. Management should consider these issues when reviewing SLA and FCPs. The Director of Finance with the support of the NWSSP Head of Procurement is establishing an improved framework for the management of contracts. We would highlight these issues for attention as part of that process.	**High**	Noted. The Procurement and finance teams will review the finding of the MEMS report and conduct reconciliation activity based on the date to ensure that payments reflect beds in use.	31/07/2020	**Undated** Meeting to be arranged with MEMS to agree approach. Now likely to be summer 2021. Delayed due to impact of COVID.	31/08/2021

Executive Lead – Director of Workforce & Organisational Development							
ABMU 1819-043 **Staff Performance Management & Appraisal** **Report Issued 12/04/2019**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	1	Whilst there has been Board level discussion of using ESR more effectively within the Health Board, timescales for implementing supervisor self-service have not been set out yet. Whilst resource is focused on the Bridgend transition arrangements at the end of March 2019, we would recommend that responsibilities and the future ownership of ESR be agreed at Executive level and that the Lead Executive agrees Supervisor Self Service rollout plans and timescales.	**High**	As part of the review of corporate executive responsibilities, it has been agreed that responsibility for ESR will transfer from the DoF to the Director of Workforce and OD from April 2019. In preparation for the development of a full functionality deployment plan the national ESR team have already conducted a site visit (November 2018) to assess preparedness and support the development of a full functionality roll out plan. A timetable and roll out plan for the deployment ESR self-service and other un-utilised ESR functionality cannot be developed without the identification and deployment of additional resource to undertake the significant digital transformation programme. ABMU is a number of years behind other organisations in Wales in respect of the utilisation of ESR and the resourcing of the ESR team will need to be enhanced to take the required deployment forward. The pace of the deployment of ESR functionality across the Health Board will be dependent on the resource investment agreed to support this programme of work. Until this issue is resolved the timescales for full deployment cannot be agreed. However, capacity issues are subject to discussion at Executive Director level currently and it is intended to provide the Workforce & OD Committee with the vision and route map for use of the system by the end of June.	30/06/2019	**January 2020** Due to resources, there has been no further development in the role out of SSS. This currently sits within the finance directorate. **May 2021** Rollout of ESR self-service is a key priority of the annual plan. Recruitment is taking place to recruit a lead and team to support roll out. Plans will then be developed to rollout over a two-year period. ESR will transfer to Workforce and OD once staff have been recruited.	None Entered
	3	The last three available meeting minutes for the Hotel Modernisation Board, June, September and December 2018, were reviewed. Compliance figures were reported in the last two meetings, however, the Head of Support Services informed the auditor that they do not have an action plan for improving PADR compliance. Hotel Services management should ensure that the review of PADR compliance includes actions to improve current compliance levels, completion deadline dates for actions and regular progress review at local Board meetings.	**High**	The Management accept this recommendation. Working with the Associate Head of HR, the Head of Support Services and senior team will work to produce a 12 month action plan by the end of May 2019 (this take into account the Bridgend changes and the impact that this will have). This action plan will be monitored at relevant management meetings.	01/07/2019	**September 2019** Hotel services asked to present detailed action plans and a deep dive to WOD Comm. on 27.08.2019. This is being monitored by the Committee and some improvements in compliance have been noted. This recommendation should sit with the Head of Support Services. **January 2020** Delay in actions due to Pandemic. Most recent figures available (Nov 19) show a compliance rate of 37.88% **February 2021** In May ‘19 PADR was 15.51%. A campaign was introduced which peaked in April ‘20 at 71%. The current rate is 22.66%. The decline is related to COVID. The tracker which was in place for 2019 will be reintroduced with meaningful targets set for each department. Stat. & Mand. Training has increased from 47.77% in May ‘19, peaking at 67.26% in April ’20. It is currently at 64.98% (Feb ‘21). Our target is to reach 75% by September 2021. Incrementally mandatory training targets will be set (March to September) and reviewed every month in Support Service Management Board meetings.	30/09/2021

ABMU 1819-043 **Staff Performance Management & Appraisal** **Report Issued 12/04/2019** **Cont.**						**May 2021** The Chief Operating Officer and Head of Support Services are attending the June Workforce and OD committee to present their PADR recovery plans	
	Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	4	The last three Estates Management Board agendas with embedded papers were reviewed, September, October and November 2018. Although there was a standing agenda item 'Mandatory Training - PADR' there were no associated papers, although the meeting minutes did evidence limited discussion on progress at the August and September meetings. The Estates department confirmed there was no action plan. Estates management should ensure that the review of PADR compliance includes actions to improve current compliance levels, completion deadline dates for actions and regular progress review at local Board meetings.	**High**	The Management accept this recommendation. Working with the Associate Head of HR, the Assistant Director of Operations (Estates) and estates senior team will work to produce a 12 month action plan by the end of May 2019 (this take into account the Bridgend changes and the impact that this will have). This action plan will be monitored at relevant management meetings.	01/07/2019	**September 2019** Estates have been asked to present detailed action plans and a deep dive at the WOD committee on the 27.08.2019. Unfortunately they were unable to present at the meeting (but papers were submitted). This has been rescheduled for the October committee. This is being monitored by the Committee, Some improvements in compliance have been noted. This recommendation should sit with Des Kieghan Head of Estates. **January 2020** Delay in actions due to Pandemic. Most recent figures available are Nov 2019 and show a compliance rate of 36.83% **May 2021** The Chief Operating Officer and Head of Estates are attending the June Workforce and OD committee to present their PADR recovery plans	30/09/2021
ABMU 1718-046 **European Working Time Directive Portering Services** **Report Issued 21/05/2018**	**1**	There is no policy or procedure within the Health Board that supports the European Working Time Directive The Health Board should look into composing a Policy to ensure compliance with the Working Time Regulations 1998 across all staff disciplines.	**High**	Agreed. A policy/guidance will be composed.	01/09/2018	**Undated Comment by A&A** This should remain open until action confirmed as completed or issues/risk addressed by other means. We would recommend they are reviewed with the leads by the DOWOD and Head of Support Services. **May 2021** This action will be reviewed by the Director of Workforce and OD and Head of Support Services to determine the way forward.	None Entered

Executive Lead – Director of Public Health							
ABMU 1819-012 **Vaccination & Immunisation** **Report Issued 02/08/2018**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	4b	The May ChIG meeting discussed data quality issues in respect of immunisation records used for a GP cluster pilot. The Health Boards Primary Care Clinical member indicated in the preceding meeting that a review in her own practice had highlighted data cleansing issues. We would recommend cleansing of records within Primary Care be progressed via inclusion in the ChIG immunisation plan.	**Medium**	The process of data cleansing in primary care would impact on the child health department, as previous work undertaken has demonstrated that in many instances the information held on the child health system is also incorrect. Our plan is therefore to build a business case for resources to carry out data cleansing for the current backlog of data, with a view of undertaking regular data cleansing to avoid discrepancies between Primary Care and Child Health records and ensure confidence that COVER data is an accurate reflection of our current performance. This business case will be presented to the Investment and Benefits group for consideration, following the next SIG meeting in September	04/09/2018	**12th October Extraordinary SIG** The business case for regular data cleansing to avoid future discrepancies will be progressed once a workshop has been held between leads in Child health system and primary care, to understand the issues and quantify size of issue and cost of a data cleansing exercise. Progress on date and venue to be expected by November SIG. A business case/paper has been prepared by the child health directorate highlighting data quality issues following the 2013 measles outbreak. Jason Crowl to be interim lead until 31.3.19 working with Child Health senior management on the business case and workshop. Escalation to Q&S Forum requested at SIG for chair of SIG to raise concern that poor data quality is a risk impacting on population health, requesting their support for resources to do the data cleansing. **Childrens Serv's Update - Dec 2019** Additional admin resource is still required to undertake this work. SBAR has not been progressed.	None Stated

Executive Lead – Director of Nursing & Patient Experience							
ABMU 1819-009 **Fire Safety Follow Up (2)** **Report Issued 19/11/2018**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	1	The spreadsheet for monitoring risk assessments was only partially populated. The Assistant Director of Strategy advised that extra resource would be allocated to fully populate the spreadsheet going forward. We would recommend that the monitoring spreadsheet is brought up to date as currently it does not provide a comprehensive monitoring tool.	**High**	Further to additional discussions with internal audit colleagues, enhancements to the database and its use have now been agreed and will be developed. This requires additional clerical resource within the Fire Safety element of the Health & Safety Department to populate the database with all of the individual risk assessments on a line by line basis. Action required: 1. Recruit apprentice to populate database 2. Draft SOP for population, reporting and management of the risk assessment (to include escalation of "unactioned" risks) 3. Implement SOP	28/02/2019	**Audit Comment 26/04/2021** **(Follow Up Review SBU 20-21-009)** Outstanding. The database of actions to mitigate risk remains incomplete. **Management Comment** We don't currently have the facility to complete this easily. Accordingly, along with several other Health Boards, we are moving away from this, and looking to utilise facilities within Datix. We can then ensure a pyramid structure of assurances around actions, though in some sites such as Neath we attend and go through all outstanding issues. New systems have been agreed and will be implemented in May 2021. An updated spreadsheet now exists and captures number of FRA due, completed and outstanding providing compliance percentage level for each service group and will be monitored by the health & safety fires safety group. From May all FRAs completed between the meeting will be reviewed, this will enable actions that have been identified to be updated on the actions that have been completed and those outstanding, with appropriate escalation process in place.	TBD
	5	The Operational Health & Safety Group received reporting regarding fire risk assessments but this lacked detail outstanding and completed actions from risk assessments across the Health Board. The Health & Safety Committee received updates on fire risks in August 2018 through the ABMU Risk Profile report and action plan, information updated to June 2018. We would recommend that reporting to both the Operational Health & Safety Group and the Health & Safety Committee be enhanced to include action taken to address risks identified in risk assessments and risks still to be	**Medium**	This will be addressed via implementation of the database & protocol[1]. Date extended to date of March H&S Committee.	04/03/2019	**Audit Comment 26/04/2021** **(Follow Up Review SBU 20-21-009)** Outstanding. Of six risk assessment provided, none contained completed actions. Associated reporting was not identified. **Management Comment** A deep dive into issues will centre on key areas which will further inform targeted action. These areas include: • lack of fire wardens; • addressing risk assessments; • avoidance of re-naming wards (to simplify reporting over time); and • training. With additional resource for specialists to assist in relation to fire safety, then money could be saved on advisers at schemes. 30% of resource was lost at boundary change (4 whole time equivalent staff out of 12). A more comprehensive approach is required to address risk including co-ordination with asbestos removal and removing	31/07/2021

		actioned.				pipework dead legs (for purposes of legionella safety), to address fire issues in a co-ordinated manner while access is enabled.	

[1] The “database and protocol” refers to a spreadsheet used for monitoring risk assessments, which was found during the audit to be only partially complete. As part of a separate (completed) recommendation, management agreed to enhance and fully update the spreadsheet/database, and produce an accompanying SOP

ABMU 1920-006 Health & Safety Report Issued 10/03/2020	Rec Ref	Findings & Recommendation	Priority	Original Response	Original Agreed Deadline	Audit Tracker Update/Comment	Revised Deadline
	3(i)	The HSOG terms of reference indicate that it will receive reports for information and advise the HSC on a number of subjects, including KPIs. It has not received any papers on KPIs to date. We would recommend that a suite of KPIs be developed at HSOG and used for monitoring and reporting to HSC.	**Medium**	HSOG are reviewing the outcomes covering the various subjects and from this develop KPI's for the group. i.e. Actions from the various surveys'/audits/inspections/COSHH etc. - examples of KPI's: H&S subjects • Fire RA completion • Asbestos Assessments • Water assessments	31/08/2020	**Undated** KPI's being reviewed to implement a two-tier system. i.e. undertake fire risk assessments being first tier and the second being the completion of the actions in the FRA to be implemented Q1 2021/22 New Completion date March 2021 (MP) **May 2021** Asst. Director of Health & Safety to present draft KPI’s firstly to the HSOG and then to the HSC in order to go through the appropriate governance structure.	20/07/2021
	3(ii)	The operational and reporting expectations of specialist groups Within Estates Services (e.g. Medical Gases, Fire Safety, Water Safety, Safer Sharps) have not been set out with the same clarity as those for Unit groups. We would recommend that Management review the reporting expectations from the specialist groups to ensure that their objectives, work plans and reporting arrangements support the work of the H&S Operational Group and the assurances to the HSC. Additionally, has been adopted by Unit H&S groups, we would recommend that calendar arrangements be reviewed to assist in action completion. Scheduled reporting from the groups should then be included within the HSOG Forward Work Plan.	**Medium**	A review of the 14 sub-groups has taken place and it is the intention of the HB to introduce an overarching group - Water Environment & Buildings (WEB), this will concentrate on the compliances in each of the areas, all of which will have KPI's and appropriate action plans. A HB dashboard will be produced to provide an overview of compliance.	31/08/2020	**Undated** Due to challenges of COVID - 19 this has been postponed. New completion date of June 2021	30/06/2021
	4	Risks and concerns as reported through HSOG within the Estates report have lacked clear detail when transferred to the HSOG key issues report provided to the HSC. We would recommend the Key Issues report provided to the HSC be enhanced to capture clearer updates across the specialist areas which currently feature within the Estates report.	**Medium**	This will be picked up with the introduction of the WEB group	31/08/2020	**Undated** Due to challenges of COVID - 19 this has been postponed. New completion date of June 2021	30/06/2021
	8(ii)	The Terms of Reference of the Health & Safety Operational Group includes receiving information on and preparing reports on risks to the Health & Safety Committee. This would indicate that it is a route for escalation of Health & Safety risks. There is a lack	**Low**	There has been a review of the HBRR template. There should be better alignment as this progresses and a review of the ToR will take place at the next meeting in May to	30/06/2020	**Undated** All risks are being reviewed to ensure appropriate recording and reporting is in place. This	30/06/2021

		of clarity over how this interacts with the Health Board Risk Register and role of the Risk Mgmt. Group. Management should clarify the link between the HSOG and Risk Management Group.		ensure accuracy		will be included in the deep dive originally scheduled for Feb 2021 meeting. Revised completion date of June 2021	
ABMU 1920-025 **Discharge Planning** **Report Issued 24/02/2021**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	1	All patients we reviewed had some form of clinical plan in place promptly following admission, but the detail of plans varied from ward to ward, and the clear documentation of clinical management plans with content as expected by section 7.9 of the SAFER Policy was not common. Management should take steps to improve the consistency of practice in the documentation of clinical management plans and compliance with policy. Consideration should be given to progressing this as part of a quality audit & improvement initiative. Additionally, there may be merit in the implementation of standard template documentation to prompt key requirements.	**High**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of clinical management plans and include actions to provide assurance regarding implementation. Anticipated first draft for consultation end of February 2021.	Complete revision and consultation of updated policy - May 1st 2021	A revised SAFER policy is currently being written and this will be included as part of the revised policy.	
	2	The methods used across wards for setting EDDs was inconsistent - on some wards, EDDs were set by Ward Managers, and some by Ward clerks, but there was little evidence within patient notes of medical input in determining the EDD. Management should take steps to ensure that the setting of the initial EDD is undertaken as part of the initial clinical management plan documentation within patient notes.	**High**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	Complete revision and consultation of updated policy - May 1st 2021		
	3	Testing at Ward E, Neath Port Talbot Hospital, showed that EDDs are not always set within 24 hours having identified 9 patients that did not have an EDD after being admitted between 2 to 14 days earlier. Management should review the process for setting EDDs at Neath Port Talbot Hospital Ward E to ensure that they are set within 24 hours of admission in line with Policy	**Medium**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the documentation of expected date of discharge within clinical management plans, and on signal. Requirement to audit and improve recording of EDD will be included within the corporate audit tool.	Complete revision and consultation of updated policy - May 1st 2021		
	4	Several observations identified divergence from policy requirements across wards: - Records did not demonstrate senior medical review occurring on a daily basis. Discussion with the Senior Corporate Matron has identified that a senior review might not always be required for some patients on some wards. - Patients at Gorseinon and Neath Port Talbot Hospitals did not receive a daily consultant review and there were also gaps between reviews by junior doctors too, but it was considered that patients on the wards visited here did not require daily medical input. The Policy does not indicate where variation from the daily requirement would be acceptable. - Often, the times of patient reviews recorded in notes fell after midday. - Reviews undertaken at weekends were very inconsistent across all wards with the majority of patients not receiving a	**Medium**	The policy is being reviewed and revised to provide greater clarity on expectations regarding the frequency, timing and recording of senior medical review, and include actions to provide assurance regarding implementation.	Complete revision and consultation of updated policy - May 1st 2021		

		senior or junior review. Management should consider these areas of divergence from policy. Where they are considered acceptable, we would recommend policy be reviewed to accommodate them appropriately. Otherwise we would recommend action be taken to reinforce policy requirements to improve compliance.					
ABMU 1920-025 **Discharge Planning** **Report Issued 24/02/2021** **Cont.**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	5	Ward 8 at Singleton used a Weekend Handover Sheet which outlined the criteria for patient discharge over the weekend to enable nurse-led discharge. Management should consider the implementation of weekend handover sheets across all wards.	**Low**	The standard for handover will be reflected within the revised policy version.	Complete revision and consultation of updated policy - May 1st 2021		
	6	There was non-compliance with policy in that the reason for changing the EDD was not always recorded within the Clinical Portal (or SIGNAL) which meant that it was not always possible to establish if all of the changes to the EDD were appropriate. Additionally, we noted differences between EDD dates recorded in the portal and those within SIGNAL (with one ward inputting only to SIGNAL). SIGNAL being a relatively new development is not currently covered by policy. Management should clarify what is expected of staff in respect of populating systems with the EDD data and reasons for changes, particularly where more than one system is in operation. Awareness of expectations should be reinforced and policy updated to reflect systems in place.	**High**	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation	Complete revision and consultation of updated policy - May 1st 2021		
	7	Of the 55 patients tested there were ten patients where the EDD was updated beyond a patient being medically fit for discharge with the reason being related to Social Worker, Continuing Healthcare/Funded Nursing Care applications or repatriation. These do not fall under clinical reasons for change of EDD and therefore the EDD should not have been changed. Five patients at Singleton Hospital were identified as being medically fit for discharge within patient notes but this was not recorded as such within the Clinical Portal or Signal and so the EDD continued to be updated. Management should ensure all staff are trained and made aware of the appropriate reasons for updating the EDD. Consideration be given to a programme of improvement work across wards to coach staff in effective use and recording of the EDD to monitor better compliance & outcomes.	**High**	The policy is being reviewed and revised to provide greater clarity on expectations regarding adjustments to EDDs, appropriate reasons for them and how these will be documented. The policy will include actions to provide assurance regarding implementation.	Complete revision and consultation of updated policy - May 1st 2021		
	8	Whilst the ABMU Clinical Portal prompts for reasons, the field is not mandatory. Neither SIGNAL nor the Welsh Clinical Portal provide fields seeking reasons for EDD changes, so wards using them may not capture the same level of information.	**Medium**	i. A paragraph on expectations, roles and responsibilities will be enhanced within the revised policy.	Complete revision and consultation of updated policy - May 1st 2021		

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	10	Within Signal, the 'MDT d/c planning' column is utilised to record details and actions in relation to a patients discharge. There were wards at Morriston that had no comments this column in and very little detail recorded within patient's notes. We would recommend that the expected use of PSAG Boards (whether manual or electronic) be reinforced by management and direction be given to staff on expectations in respect of patient notes. Consideration should be given to including this within a programme of improvement work across wards to coach staff in effective implementation of this aspect of discharge planning & documentation and to monitor improvements in practice.	**High**	i. To be captured as a requirement within the new Audit Tools. Which will be included within the appendices to the revised policy.	Complete revision and consultation of updated policy - May 1st 2021		
				ii. A case will be presented to signal user group to consider if a standardised approach to board rounds could be designed within phase 3 of signal.	31/03/2021	The Head of Nursing (Patient Flow) has only very recently taken up post, and will be working on this.	31/05/2021
	11	On Ward 6 at Singleton there was evidence to suggest that arrangements for patients discharge would wait until after the patient is medically fit for discharge rather than this process being ongoing from admission. Management should ensure that discharge planning is undertaken by ward staff from the point of admission in line with policy.	**Medium**	The standards will be reflected in the rewording of the revised policy	Complete revision and consultation of updated policy - May 1st 2021		
	13	Staff at Singleton ward 8 highlighted that patient notes available at ward level were not comprehensive - interventions provided by staff from Therapies were held separately. We recommend that management take steps where necessary to ensure that ward-level patient records provide a comprehensive, up-to-date account of the patient's care and steps taken to ensure a safe discharge.	**Medium**	Revised policy will clarify how discharge planning will be recorded following the introduction of new systems.	Complete revision and consultation of updated policy - May 1st 2021		
	14	There were mixed findings in relation to Information Governance with different wards having different concepts relating to the amount of patient data permitted to be displayed within patient and visitors view. However, in general, full patient names were visible on most Signal PSAG Boards with some Wards displaying dates of birth,	**Medium**	i. Service Group Nurse Directors will re-issue the information governance policy outlining what patient identifiable information can be displayed publicly.	31/03/2021	The Head of Nursing (Patient Flow) has only very recently taken up post, and will be working on this.	31/05/2021

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	15	A review of Signal at Singleton in particular, has shown that staff are populating the system with detailed patient information which is not duplicated within patient notes. Staff report the system has had a positive impact at ward levels, reducing workloads and making patient information more accessible - However, once Signal is optimised across the Health Board, it will only have capacity to store information for a maximum of 30,000 patients which translates to storing information for approximately 6 months post patient discharge. After which, all of the detailed entries within Signal will be deleted. It is noted that the introduction of electronic nursing notes will overcome some of the above, however this system only includes entries from Nurses and assessments undertaken. Management should review the arrangements for documenting patient records to ensure that a full patient history is maintained post discharge.	**High**	This identified risk will be escalated to the Signal User Group and any unresolved risk assessed and added to the corporate risk register for monitoring until action is identified to resolve it.	31/03/2021	The Head of Nursing (Patient Flow) has only very recently taken up post, and will be working on this.	31/05/2021
	16	Noting the number of areas of non-compliance with policy highlighted, it is recommended that consideration be given to progressing as part of a quality audit and improvement initiative.	**Medium**	Development of a new Corporate Audit Management Tool, and standard operating procedure outlining the roles, responsibilities and expectations (including frequency) for service group audit of compliance, and to identify improvements and actions relating to the discharge policy.	31/03/2021	The Head of Nursing (Patient Flow) has only very recently taken up post, and will be working on this.	31/05/2021

Executive Lead – Director of Strategy							
ABMU 1819-007 **Systems Declarations of Interest & Risk Management** **Report Issued 11/04/2019**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	10	The Standards of Business Conduct require a declaration of interests proforma to be completed at all procurement exercises over £5 in value. Where NWSSP Procurement Services manage the procurement exercise, they are responsible for the issuing and completion of the DOI forms for all relevant staff. Internal procurement exercises are also separately progressed by UHB Estate staff (the audit was unable to quantify the number/value of these exercises). DOI forms were not routinely completed (by Estates or other UHB staff) at these internally managed procurement exercises. The DOI proforma should be completed at all procurement exercises (including Estates, client, end users as appropriate) in accordance with the Standards of Business Conduct.	**Medium**	Agreed.	30/04/2019	**26/07/2019** This will be actioned via Estates Board to all Senior Staff – Procurement colleagues will be required to provide training (over £5k). Added to Estates Board agenda for discussion. **16/12/2019** Assistant Director of Operations – Estates will be writing to all staff that have raised orders in January to ask them for declaration of any known interests. Meeting scheduled for 15th January 2020 for discussion.	None Entered
	14	Management were able to explain how the capital allocations from the 2018/19 discretionary programme were determined, based on risk, however no audit trail was available to verify the use of OAKLEAF to drive this process. It was also noted that the Estates Operating Procedures were out of date, and the funding allocation procedure described by management was not formally documented. Estates Operating Procedures should be updated, to set out the required processes associated with the recording of identified risks, and in the risk prioritised allocation of discretionary capital.	**Medium**	Agreed. The Department will review how this is achieved in light of the transfer of the Risk Register onto the DATIX system.	30/09/2019	**Update 16/12/2019** High & Significant risks for the two main sites have been entered onto DATIX. The risk team have been working with us to develop the ability to record two separate risks. Meetings are planned for January 2020 to review risks before making them live on Datix. **Update 31/01/2020** Meeting took place. Work is ongoing. It is planned to have transfer complete of High and Significant risks by May.	None Entered
	16	A significant number of estate-related risks were captured on Unit risk registers across the Health Board. Unit risk registers (as held in the DATIX risk management system) were reviewed during the audit, and circa 100 risks were identified which had been categorised as relating to “Environment, Estates and Infrastructure.” There is currently no formal process by which Estates were involved in the assessment or review of such risks held within the DATIX system. The only means by which the department would be aware of these risks, was if the Unit notified Estates of an issue which may require repair/resolution. There is a risk, therefore, that the OAKLEAF system may not adequately reflect the full range of estate risks identified across	**Medium**	Agreed. The Department are starting discussions on how to transfer its Risk Register onto DATIX. Once this is achieved, the Department will be able to capture all risk associated with the Estate from all of the Service Directorates. The OAKLEAF system will then be used only to hold its Condition Appraisal information, with DATIX	30/09/2019	**Update 26/07/2019** By moving to the DATIX system, Estates will be able to see all Estates assigned risks, ensuring fully captured and will avoid duplication. **Update 16/12/2019** Once the meeting has taken place in January to review risks on DATIX the database will go live. We are already linking with the Unit Risk Management Team to ensure all risks are captured	None Entered

ABMU 1819-007 **Systems Declarations of Interest & Risk Management** **Report Issued 11/04/2019** **Cont.**		the UHB (particularly noting concerns that the OAKLEAF system may in general not be sufficiently up to date, given the lack of recent Health Board-wide estate survey: as highlighted at the 2016/17 Backlog Maintenance audit). Estates should review the estate-related risks captured at Unit risk registers, and ensure these are reflected in OAKLEAF, where appropriate.		being the Department's Risk Register.			
	Rec Ref	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	17	It was observed that "assurance reports" provided by the Assistant Director of Operations (Estates) to the Director of Strategy and (verbally) to the Health & Safety Committee were somewhat disparate, and did not reference the Estates risk register, or the respective risk ranking of each of the compliance areas. Reporting of the key estates compliance issues to the responsible Director and elsewhere should include linkage to the risk register and the risk-ranked prioritisation of the issue/s being reported.	**Medium**	Agreed. Management will review the format of the report to include a risk rating for each of the issues being highlighted, with a view to prioritising these issues within the report.	31/05/2019	**Update 26/07/2019** A coordinated report without risks has been presented to H&S Group. Also presented a report to main H&S Committee on Estates Risks. A new report will be developed for September's Committee using Risk ratings. It was agreed this format will be used going forward. **Update 31/01/2020** Reports have been presented at H&S Committee on Estates issues. The new WEB meeting will further enhance this operational H&S group.	None Entered

		Executive Lead – Executive Medical Director					
SBU 1920-021 **WHO Checklist** **Report Issued 23/07/2019**	**Rec Ref**	**Findings & Recommendation**	**Priority**	**Original Response**	**Original Agreed Deadline**	**Audit Tracker Update/Comment**	**Revised Deadline**
	1(a)	The Health Board has developed Local Safety Standards for Invasive Procedures (LocSSIPs) which were based on National Standards (NatSSIPs). Roles and responsibilities have been defined in the LocSSIPs, and they are available on the Theatres SharePoint. Although published on Theatres Sharepoint and so available to staff, they were yet approved for implementation across the Health Board formally. The Executive Medical Director or designated representative should agree standards corporately before wider dissemination. As part of this we would recommend that consideration be given to the clarification of responsibilities for recording data within TOMS.	**Medium**	Executive Medical Director to establish working group to agree standards for LocSSIPs	01/11/2019	**Update 19/02/2021** The work planned has been paused due to COVID. The intention is to refresh this work in 2021/22. Request extension for completion by Q4 2021/22	31/03/2022
	1(b)	The former chair of the Theatres Board indicated that Units would need to review their SOPs for specific procedures that are only commonly undertaken on their sites. The Theatres Board should set target dates for completion of the review of SOPs by Units and monitor their completion. Executive Medical Director approval should be sought for variations to corporate standards.	**Medium**	Theatres Board to set target dates for completion of review of SOPs and monitor completion; Exec MD to agree process for exception requests through working group.	01/11/2019	**Update 19/02/2021** The work planned has been paused due to COVID. The intention is to refresh this work in 2021/22. Request extension for completion by Q4 2021/22	31/03/2022
	4	The LocSSIPs were not clear or consistent on the level of observational audit required and how it should be reported. We would recommend that management review and clarify the direction within LocSSIPs in respect of the level of clinical audit expected and the groups to which it should be reported.	**Medium**	Working group referred to above to review all LocSSIPs to clarify the level of clinical audit required and how this is reported	01/11/2019	**Update 19/02/2021** The work planned has been paused due to COVID. The intention is to refresh this work in 2021/22. Request extension for completion by Q4 2021/22	31/03/2022